SECTION 2 **RECIPIENT ELIGIBILITY**

Eligibility Determination

For most recipients, Medicaid eligibility is determined by the local DSS in the county in which the individual resides. Applicants may enroll in person or by mail. Applicants for Medicaid are evaluated on income level, available financial resources, and criteria related to categorical standards such as age and disability. Families receiving Work First Family Assistance and individuals receiving Special Assistance benefits also receive Medicaid.

If a household's income exceeds the allowable level, the applicant may be eligible for Medicaid after sufficient medical expenses are incurred that would meet a deductible. The deductible is calculated using a formula set by law.

Aged, blind, and disabled individuals (including children) who receive Supplemental Security Income (SSI) are automatically entitled to N.C. Medicaid benefits and are not required to make a separate Medicaid application at the county DSS office. SSI eligibility is determined by the Social Security Administration. If an SSI recipient needs Medicaid coverage prior to the effective date of the SSI coverage, the recipient may apply for this coverage at the county DSS office. The recipient must apply for retroactive SSI Medicaid within 60 days (90 days with good cause) from the date of the SSI Medicaid approval or denial notice in order to protect the SSI retroactive period.

Eligibility Categories

N.C. Medicaid recipients receive benefits in the following assistance categories:
- Medicaid – Work First Family Assistance (AAF)
- Medicaid – Aid to the Aged (MAA)
- Medicaid – Aid to the Blind (MAB)
- Medicaid – Aid to the Disabled (MAD)
- Medicaid – Families and Children (MAF)
- Medicaid – Families and Children, Family Planning Waiver (MAF-D)
- Medicaid – Infants and Children (MIC)
- Medicaid – Pregnant Women (MPW)
- Medicaid – Special Assistance to the Blind (MSB)
- Foster Care; Adoption Subsidy (HSF; IAS)
- Special Assistance – Aid to the Aged (SAA)
- Special Assistance – Aid to the Disabled (SAD)
- Medicaid – Medicare-Qualified Beneficiaries (MQB)
- Medicaid – Refugees (MRF)
- Medicaid – Refugee Assistance (RRF)

Providers who have general eligibility questions should instruct their patients to contact their local DSS office. For a list of all the local DSS offices, please refer to the following link at http://www.dhhs.state.nc.us/dss/local/.

When Does Eligibility Begin?

An individual is eligible for Medicaid the **month** in which all categorical and financial conditions of eligibility are met. If all requirements are met during the month of application, eligibility begins the first day of that month.

If the individual has a deductible or excess resources and all other conditions are met, eligibility begins on the **day** of the month on which the deductible is met or the resource is reduced to the allowable limit. The Medicaid deductible is met by incurring medical expenses **for which the individual is responsible for paying** from personal funds during the certification period in which assistance is requested. The Medicaid certification period (the period for which the deductible is computed) is typically six months.

Eligibility for non-qualified alien residents is approved for emergency services only and is limited to only the services required to treat the emergency condition. To be eligible for emergency services, the individual must still meet all other eligibility requirements, such as income, resources, age, and/or disability criteria.

Eligibility for most recipients ends on the last day of the month. Exceptions to this are a presumptively eligible pregnant woman whom the county DSS has determined to be ineligible and a non-qualified alien eligible to receive emergency services only.

Retroactive Eligibility

Retroactive coverage may be approved for up to three calendar months prior to the month of the application if the applicant meets all eligibility conditions in the retroactive period. Medicaid will pay for covered services received during the retroactive period provided that all other Medicaid guidelines are met. Providers may choose to accept or decline retroactive eligibility. However, the provider's office policy should be consistently enforced. If a provider accepts retroactive eligibility, all payments made by the recipient must be reimbursed to the recipient when the provider files the claim to Medicaid.

Eligibility Reversals

In some cases an application for Medicaid benefits is initially denied and then later approved due to a reversal of a disability denial, a state appeal or a court decision. Because some of these appeals and reversals are not final for many months, the county DSS can request an override of the claims filing time limit from DMA. Written notice is provided to the recipient and to the county DSS when the time limit override is approved. Recipients are instructed to immediately notify the provider of retroactive approval. Failure to do so will result in the recipient being financially liable for the services provided. Refer to **Eligibility Denials** on page 2-14 for additional information.

Medicaid Identification Cards

Individuals approved for Medicaid receive a monthly Medicaid identification (MID) card as proof of their eligibility. The MID card indicates eligibility and restrictions that apply to the recipient. It also shows information necessary for filing claims, including the recipient's MID number, date of birth, insurance information, Medicaid Managed Care information, and recipient eligibility dates for which the card is valid.

A recipient's eligibility and managed care provider may change from month to month. Therefore, new MID cards are issued at the beginning of each month. The new card shows valid dates through the current calendar month. The "From" date may show eligibility for prior months in addition to the current calendar month.

Providers must request that recipients present their current MID card as proof of eligibility for the dates of services rendered. Recipients must present a valid MID card at each provider visit. Failure to provide proof of eligibility may result in the recipient being financially liable for the service provided as the provider can refuse to accept the recipient as a Medicaid client.

Blue and Pink Medicaid Identification Card Information

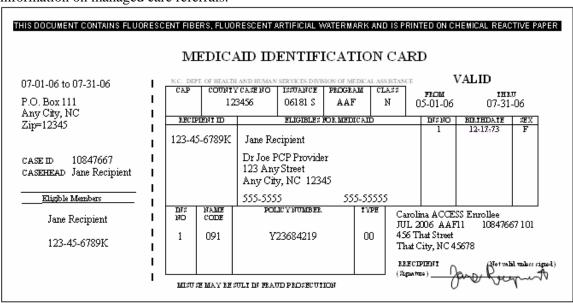| Field	Description
Insurance Number	A number in this field indicates that the recipient has specific third party insurance.
Name Code	A 3-digit code identifies the name of the third party insurance carrier.
	Note: The **Third Party Insurance Code Book** is available on DMA's Web site at http://www.dhhs.state.nc.us/dma/tpr.html and provides a key to the insurance codes listed in this field.
Policy number	If the recipient has coverage with a third party insurance carrier, the recipient's insurance policy number is listed in this field.
Type	A 2-digit code indicates the type of coverage provided in this policy. The coverage codes and types of coverage are listed below:
	00 – Major Medical Coverage
	01 – Basic Hospital with Surgical Coverage
	02 – Basic Hospital Coverage Only
	03 – Dental Coverage Only
	04 – Cancer Coverage Only
	05 – Accident Coverage Only
	06 – Indemnity Coverage Only
	07 – Nursing Home Coverage Only
	08 – Basic Medicare Supplement
	10 – Major Medical and Dental Coverage

Field	Description
	11 – Major Medical and Nursing Home Coverage
	12 – Intensive Care Coverage Only
	13 – Hospital Outpatient Coverage Only
	14 – Physician Coverage Only
	15 – Heart Attack Coverage Only
	16 – Prescription Drugs Coverage Only
	17 – Vision Care Coverage Only
Recipient Name and Address	The name and address of the head of the household is listed to the right of the insurance data.
Recipient Name and Address – Carolina ACCESS (CCNC) Enrollees	If the recipient is enrolled with a CA (CCNC), the words "Carolina ACCESS Enrollee" appear on the card.
Date	The month and year for which the card was issued for are listed here.
Signature	The recipient must sign the MID card where indicated.

Blue Medicaid Identification Card

The card lists the casehead of the family and other eligible persons. Each eligible recipient has a specific recipient MID number. A recipient is eligible for Medicaid only if his/her name and MID number appear on the card.

CA (CCNC) enrollees are identified by the phrase "Carolina ACCESS Enrollee" on the MID card. The name of the CA (CCNC) PCP, the PCP's address, and the daytime and after-hours telephone numbers for the practice are also listed on the card. The date listed under the phrase "Carolina ACCESS Enrollee" indicates that the recipient is enrolled with the PCP listed on the card for that month. Providers must contact the health plan listed on the recipient's MID card to obtain referral and authorization before providing treatment.

Refer to **Carolina ACCESS Referrals and Authorization** on page 4-12 for additional information on managed care referrals.

Family Planning Waiver Card

Effective October 1, 2005, the Medicaid Family Planning Waiver (also known as the "Be Smart" program) was implemented. The waiver is designed to reduce unintended pregnancies and improve the well-being of children and families in North Carolina by extending eligibility for family planning services to eligible women ages 19 through 55 and men ages 19 through 60 whose income is at or below 185% of the federal poverty level.

The "Be Smart" Family Planning Waiver provides for **one** family planning annual exam and **six** follow up family planning exams per 365 days. The waiver also provides birth control for eligible recipients.

A family planning service is:
- Annual physical exam (includes one pap test, STD testing and treatment, HIV testing)
- Follow-up family planning visits
- Pregnancy testing and counseling
- Referrals
- Birth control methods (Medicaid covered and FDA approved)

Birth Control methods include:
- Birth control pills
- Depo-provera
- Contraceptive implants
- Diaphragm fitting
- Emergency contraception
- Intrauterine Device (IUD)
- Natural family planning
- NuvaRing
- Ortho Evra
- Male and female sterilizations

The "Be Smart" Family Planning Waiver does not pay for the following services:
- Abortions
- Ambulance
- Dental
- Durable medical equipment
- Infertility
- Inpatient hospital
- Home Health
- Optical
- Treatment for AIDS
- Treatment for cancer
- Sick Visits

Problems or complications discovered during a family planning visit or caused by a family planning procedure are not covered by the "Be Smart" Family Planning Waiver. For services not covered, call your local DSS for a list of providers who offer affordable or free care.

There is no co-payment for family planning waiver visits or prescriptions.

A new Medicaid eligibility category, MAF-D has been created for the waiver. The eligible recipient will be identified by a blue Medicaid card with the following statement **"FAMILY PLANNING WAIVER: RECIPIENT ELIGIBILE FOR LIMITED FAMILY PLANNING SERVICES ONLY."** The pharmacy stub has the following statement: **"Family Planning Limited."**

Only one name will be listed on the Medicaid card. Recipients are not required to enroll in Carolina ACCESS.

THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER

MEDICAID IDENTIFICATION CARD

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

07-01-06 to 07-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID   10847667
CASEHEAD   Jane Recipient

_____
     Eligible Members

     Jane Recipient

     123-45-6789K

Family
Planning
Limited

VALID

CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU
	123456	06181 S	MAF	D	07-01-06	07-31-06

RECIPIENT ID	ELIGIBLE# FOR MEDICAID	IN# NO	BIRTHDATE	SEX
123-45-6789K	Jane Recipient *** Family Planning Waiver *** Recipient Eligible For Limited Family Planning Services Only	1	08-02-1971	F

IN# NO	NAME CODE	POLICY NUMBER	TYPE

JUL 2006 MAF34   10847667 101
456 That Street
That City, NC 45678

RECIPIENT   (Not valid unless signed)
(Signature) _____ Jane Recipient

MISUSE MAY RESULT IN FRAUD PROSECUTION

*NOTE: For a complete list of covered services through the "Be Smart" Family Planning Waiver program, visit DMA's website at:

http://www.dhhs.state.nc.us/dma/MFPW/MFPW.htm
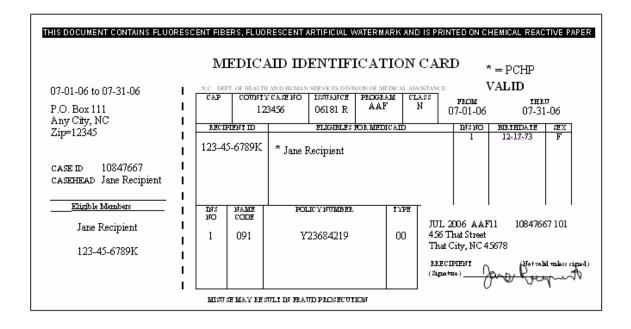
Piedmont Cardinal Health Plan Card

Effective April 1, 2005, Piedmont Behavioral Healthcare began operating under a managed care plan which applies to Medicaid recipients who get their Medicaid cards from Rowan, Stanly, Union, Davidson, and Cabarrus counties. The new managed care plan is known as Piedmont Cardinal Health Plan (PCHP). All Medicaid mental health, development disabilities and substance abuse (MH/DD/SA) services for individuals receiving Medicaid from one of the 5 counties listed above are provided through PCHP. This includes services in the Innovations waiver, which replaces CAP-MR/DD in the five county Piedmont area.

PCHP is paid a flat, per-member-per-month payment and PCHP in turn arranges and pays for MH/DD/SA services for recipients in the catchment area. DMA does not authorize, prior approve, or reimburse individual providers for these services.

All Medicaid recipients in the catchment area are covered by the PCHP with the exception of the following groups:
- Medicare Qualified Beneficiaries
- Refugees
- Non-qualified aliens or qualified aliens during the five year ban

If the recipient is enrolled in the Piedmont Cardinal Health Plan, the letters "PCHP" are printed on the card. If the recipient is enrolled in the Innovations plan, both "PCHP" and "CM" or simply "CM" are printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed. Providers who are interested in applying to participate in the PCHP network should call Piedmont Provider Relations at 1-800-958-5596.
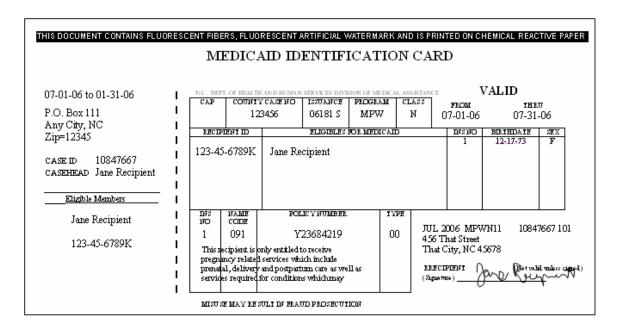
Pink Medicaid Identification Card

The pink MID card indicates the recipient is eligible for pregnancy-related services only. Only the name of the eligible pregnant woman is listed on the card. No other recipients are listed on the card. A message is printed on the card stating that eligibility is limited to services relating to pregnancy and conditions that may complicate the pregnancy. If a second message appears on the MID card stating the recipient is presumptively eligible only, coverage is limited to ambulatory care.

CA (CCNC) enrollees are identified by the phrase "Carolina ACCESS Enrollee" on the MID card. The name of the CA (CCNC) PCP, the PCP's address, and the daytime and after-hours telephone numbers for the practice are also listed on the card. The date listed under the phrase "Carolina ACCESS Enrollee" indicates that the recipient is enrolled with the PCP listed on the card for that month. Providers must contact the PCP listed on the recipient's MID card to obtain referral and authorization before providing treatment.

Refer to **Carolina ACCESS Referrals and Authorization** on page 4-12 for additional information on Managed Care referrals.

If the recipient is enrolled in the Piedmont Cardinal Health Plan, the letters "PCHP" are printed on the card. If the recipient is enrolled in the Innovations plan, both "PCHP" and "CM" or simply "CM" are printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed.

Buff MEDICARE-AID ID Card

The buff-colored MEDICARE-AID ID card, referred to as the Medicare Qualified Beneficiary (MQB-Q class) card, indicates the recipient is eligible for the MEDICARE-AID Program. If both Medicare and Medicaid allow the service, Medicaid will pay the lesser of the Medicare cost-sharing amount or the Medicaid maximum allowable for the service less the Medicare payment.

Recipients with a buff MEDICARE-AID ID card are not eligible to enroll in the Medicaid Managed Care programs.

Buff MEDICARE-AID ID Card Information

Field	Description
Program	The 3-character code indicates the recipient's coverage category.
Issuance	The 5-digit Julian date and letter (R or S) indicates the date the card was prepared and when the card was mailed.
Valid From – Thru	The From and Thru dates indicate the eligibility period. The From date may show eligibility for prior months in addition to the current calendar month. The Thru date is the last day of the eligibility in the current month.
Recipient ID	This refers to the unique MID number assigned to the recipient. The MID number is a 9-digit number followed by an alpha character.
Insurance Name Code	A 3-digit code identifies the name of the third party insurance carrier. **Note**: The **Third Party Insurance Code** book is available on DMA's Web site at http://www.dhhs.state.nc.us/dma/tpr.html and provides a key to the insurance codes listed in this field.
Birth Date	The recipient's date of birth is listed by month, day, and year.
Sex	The recipient's gender is listed in this field.
County Number	A 2-digit code indicates the county that issued the card to the recipient.
Case Identification Number	An 8-digit number is assigned to the head of household. (Refer to this number when requesting assistance from the recipient's county DSS office.)
County District Number	A 3-digit number indicates the district. This information is only used by the county.
Recipient Name and Address	The name and address of the head of household is listed in this area.
Signature	The recipient must sign the MID card where indicated.

THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER

CUT ALONG DOTTED LINES

MEDICARE-AID ID CARD
N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

NOTICE TO RECIPIENT

USE OF CARD – This card is proof of eligibility for MEDICARE-AID for the month(s) shown in the Valid From and Thru Dates. You will receive a card each month you are eligible. It is to be used with your MEDICARE card so that your medical providers can bill the MEDICAID program for MEDICARE cost sharing. Lost cards may be replaced at the county DSS. Always notify your caseworker of any change in your income, resources or living situation. This card is valid only for medical care and services covered by both Medicare and Medicaid.

RIGHT TO RECONSIDERATION REVIEW – You have the right to request a review if a provider bills you cost sharing amounts that you expected to be paid by the Medicaid program. To ask for a review, write to: DMA, 2519 Mail Service Center, Raleigh, N.C. 27699-2519 within 60 days of receiving the bill.

FRAUD – Use of this card by anyone not listed on the card is fraud and is punishable by a fine, imprisonment or both.

DO YOU HAVE QUESTIONS? – If you have questions about using your ID Card or your Medicaid eligibility, please contact your county department of social services.

VALID

FROM 07-01-06   THRU 07-31-06

PROGRAM	ISSUANCE
MQB	06181

RECIPIENT I.D.	DNS. NAME CODE	BIRTH EDATE	SEX
123-456-789K	091	08-28-CCYY	F

JUL 2006 MQB 61 76543210 004

Jane Recipient
123 Any Street
Any City, NC 12345

(Signature) _____
(Not valid unless signed)

NOTICE TO PROVIDERS

ENROLLMENT – To receive payment you must be enrolled with Medicare and North Carolina Medicaid. If not enrolled, call DMA Provider Services at 919-855-4050 for information and forms.

BENEFITS – Medicaid coverage for the recipient of this card is limited to Medicare cost sharing for Medicare and Medicaid covered services. If your services are not billable to Medicare, you cannot bill the Medicaid Program for services for this recipient.

USE OF CARD – Use this card with the recipient's MEDICARE card as proof of eligibility for MEDICARE-AID benefits.

BILLING – Bill all claims to the Medicare carrier. Once Medicare payment has been received, file a Medicaid claim. Show Medicare payment, plus any penalties or outpatient psychiatric reductions, if applicable, as a third party payment on the claim form.

County-Issued Medicaid Identification Cards

The county DSS office has the authority to issue MID cards to recipients in an emergency (when the original card is incorrect or has been lost or destroyed), for new applicants or for retroactive eligibility dates. County-issued MID cards are identified by the word "EMERGENCY" stamped on the top margin of the MID card.

Verifying Eligibility

A recipient's eligibility (PCP) status may change from month to month if financial and household circumstances change. For this reason, providers may request that Medicaid recipients provide proof of eligibility each time a service is rendered. A MID card with valid From and Thru dates covering the date(s) of service is proof of eligibility.

If a recipient no longer meets eligibility requirements, a written notice is mailed to the recipient at least 10 working days before the eligibility period ends. Should a recipient state that the MID card has not been received by mail, the provider should ask if a notice regarding a change in their eligibility status has been received. If the recipient has received a status change notice, the provider should inquire as to the nature of the change.

Recipients requesting services without proof of insurance or Medicaid coverage can be asked to pay for the services received. However, since individuals and families who are Medicaid-eligible have incomes ranging from as low as 34 percent of the federal poverty level up to 200 percent of the federal poverty level, most do not have the financial means to pay for care. Therefore, DMA provides additional methods for recipient eligibility verification.

Verification Methods

Although the recipient's MID card is the most expedient method for eligibility verification, eligibility can also be verified using the following methods:

Automated Voice Response System – Medicaid eligibility can be verified using the Automated Voice Response (AVR) system. Eligibility verification is available for services provided on the date of the inquiry as well as for services provided within the past 12 months. Refer to Appendix A for information on using the AVR system.

Electronic Data Interchange – Interactive eligibility verification programs are available from approved Electronic Data Interchange (EDI) vendors. These vendors interface directly with the Medicaid recipient database maintained by EDS. Refer to Electronic Data Interchange Services on page 10-3 for additional information.

DMA Claims Analysis – To verify eligibility for dates of service over 12 months old, contact DMA Claims Analysis at 919-855-4045.

Transfer of Assets

Medicaid reimbursement for specific home care services may be affected by the transfer of assets policy that applies to certain categories of Medicaid recipients. This policy is similar to the transfer of assets requirements currently in place for Medicaid recipients receiving care through nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR), as well as for those recipients participating in the Community Alternatives Programs.

Services Included in the Policy

The Medicaid services affected by the policy are:

- Durable Medical Equipment (DME), including the supplies provided by DME providers

- Home Health fee schedule supplies provided by Private Duty Nursing (PDN) providers to PDN patients (the nursing care is not included in this policy)

- Home Health Services, including the supplies provided by home health agencies

- Home Infusion Therapy

- Personal Care Services in private residences (PCS and PCS Plus)

Medicaid Recipients Subject to the Policy

The transfer of assets policy applies to individuals in the following Medicaid eligibility categories:
- Medicaid – Aid to the Aged (MAA)
- Medicaid – Aid to the Disabled (MAD)
- Medicaid – Aid to the Blind (MAB)
- Medicare Qualified Beneficiary (MQB-Q)

Adult care home providers should note that this policy does not apply to their residents receiving state or county Special Assistance. It does apply to a private pay adult care home resident if the individual is in one of the four eligibility categories (MAA, MAD, MAB, or MQB-Q).

Transfer of Assets Determination

The county DSS will make a transfer of assets determination when made aware that a recipient is seeking one of the specified home care services. After the process is completed, a determination is made that will apply to any of the specified services. A separate determination for each service is not required. The determination may result in a sanction period if the recipient has transferred assets within the time frame specified by Medicaid eligibility guidelines. Refer to the Adult Medicaid Manual, Section MA-2240 Transfer of Resources on the DMA Web site. The recipient is not eligible for Medicaid reimbursement of specified home care services during a sanction penalty period.

Provider Access to Transfer of Assets Information

Providers may access the AVR system to get a recipient's transfer of assets status as of a specified date. Refer to Section 2, Verifying Eligibility in this billing guide. Providers will receive one of the following AVR system responses:

- The recipient has not been assessed. The provider should ask the recipient to contact the county DSS to begin a transfer of assets assessment.
- The recipient is in a penalty period for the given date of service and claims for the specified services will be denied.
- The recipient is not in a penalty period for the given date of service.

The AVR system provides information that is in the claims processing system at the time of the inquiry. Because a penalty period can be applied retroactively, transfer of assets information for a given date may change after the provider obtains the information.

Eligibility Denials

If claims are denied for eligibility reasons, the following steps should help resolve the denial and obtain reimbursement for covered dates of service for eligible recipients.

Step 1 **Check for Errors on the Claim**	Step 2 **Check for Data Entry Errors**	Step 3 **When All Information Matches**
Compare the recipient's MID card to the information entered on the claim. If the information on the claim and the MID card do not match: • Correct the claim and resubmit on paper or electronically as a new day claim. If the claim is over the 365-day claim filing time limit: • Request a time limit override by submitting the claim and a completed Medicaid Resolution Inquiry form. Include a copy of the remittance advice (RA) or other documentation of timely filing. If the claim was originally received and processed within the 365-day claim filing time limit: • Resubmit the claim on paper or electronically as a new day claim ensuring that the recipient's MID number, provider number, "from" date of service, and total	Compare the RA to the information entered on the claim. If the RA indicates the recipient's name, MID number, or the date of service has been keyed incorrectly: • Correct the claim and resubmit on paper or electronically as a new day claim. If the claim is over the 365-day claim filing time limit, follow the instructions in Step 1 for requesting a time limit override. If the claim was originally received and processed within the 365-day claim filing time limit, follow the instructions in Step 1 for resubmitting the claim.	Verify that the recipient's eligibility information has been updated in the state eligibility file by calling the AVR system. If the AVR system indicates that the recipient is ineligible: • Submit a Medicaid Resolution Inquiry form to DMA Claims Analysis. Include a copy of the recipient's MID card, the claim, and the RA. Mail to: DMA Claims Analysis 2501 Mail Service Center Raleigh, NC 27699-2501 The Claims Analysis unit will review and update the information in EIS and resubmit the claim. **Do not mail eligibility denials to EDS, as this will delay the processing of your claim.**

billed match the original claim exactly.		

Refer to **Resolving Denied Claims** on page 8-1 for additional information. Refer to **Appendix A** for information on using the AVR system.

Explanation of Benefits (EOBs) for Eligibility Denials

Article I. EOB	Message	Explanation
10	Diagnosis or service invalid for recipient's age.	Verify the recipient's MID number, the date of birth, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis*.
11	Recipient not eligible on service date.	Follow the instructions outlined in Steps 1, 2, and 3 on page 2-14.
12	Diagnosis or service invalid for recipient sex.	Verify the recipient's MID number, the date of birth, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis*.
84	Recipient is partially ineligible for service dates. Resubmit a new claim billing for only eligible dates of service.	Verify eligibility and coverage dates using the AVR system. Resubmit the claim for eligible dates of service only.
93	Patient deceased per state eligibility file.	Verify the recipient's MID number and the date of service. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis*.
120	Recipient MID number missing. Enter MID and submit as a new claim.	Verify the recipient's MID number and enter it in the correct block or form locator. Resubmit to EDS as a new claim.
139	Services limited to presumptive eligibility.	Verify from the recipient's MID card that on the date of service the recipient was eligible for all prenatal services, delivery, and postpartum care as well as for services required for conditions that may complicate the pregnancy on the date of service. If a second "presumptive eligibility" message does not appear on the MID card, send the claim and a copy of the RA to DMA Claims Analysis*.

EOBs for Eligibility Denials, continued

Article I. EOB	Message	Explanation
143	MID number not on state eligibility file.	Follow instructions in Steps 1 and 2 on page 2-14. Make corrections, if necessary, and resubmit to EDS as a new claim. If the MID card is not available, obtain the recipient's correct MID number through the AVR system by using the Social Security Number (SSN) and date of birth. If recipient's SSN is unknown, call DMA Claims Analysis* to obtain the correct MID number.
191	MID number does not match patient name.	Verify the recipient's name and MID number with the MID card. If all information is correct, the denial may have occurred because the recipient's name has been changed on Medicaid's records since the card was issued. Call EDS Provider Services to verify the patient's name. Correct and resubmit to EDS as a new claim.
292	Qualified Medicare Beneficiary – MQB recipient	If services billed are covered by Medicare, file charges to Medicare first.
		For dates of service prior to October 1, 2002, attach the Medicare voucher to the Medicaid claim.
		For dates of service between October 1, 2002 and September 5, 2004, enter the Medicare payment on the Medicaid claim. If services are not covered by Medicare, verify eligibility benefits using the AVR system to see if the recipient's eligibility has been changed to full benefits. If so, resubmit the claim to EDS. If the recipient's status is still MQB, no payment can be made by Medicaid for services not paid by Medicare.
		For dates of service on or after September 6, 2004, attach the Medicare voucher to the Medicaid claim. Professional charges will be reimbursed a specific percentage of the coinsurance and deductible in accordance with the Part B reimbursement schedule.

* Refer to Appendix C-8 for the address.

24 – Visit Limitation

The N.C. General Assembly passed a law that allows Medicaid recipients up to 24 ambulatory medical visits per fiscal year (July 1 – June 30). These visits include visits to any one or

combination of the following: physicians' offices, outpatient clinics, optometrists, chiropractors and podiatrists. The services listed below do not count toward the 24 visit limit.

1. Services provided to recipients under 21 years of age

2. Health Check examinations provided to recipients under 21 years of age

3. Home health services

4. Inpatient hospital services (inpatient physician services are not exempt from the 24 visits)

5. Emergency departments

6. Services provided to residents of nursing facilities or intermediate care facilities for the mentally retarded (ICF-MR)

7. Prenatal and pregnancy-related services

8. Dental services

9. Mental health services subject to prior approval

10. Recipients receiving Community Alternative Program (CAP) services

11. Services covered by both Medicare and Medicaid

How to Request an Exemption

An exemption to the 24 ambulatory medical visit limit must be requested by the provider who is most knowledgeable about the recipient's condition. An exemption may be approved when a recipient has any life threatening illness or terminal stage of any illness (as supported by the physician's documentation). Examples of life threatening illnesses may include, but are not limited to the following:

1. End-stage lung disease

2. End-stage renal disease

3. Chemotherapy and/or radiation therapy for malignancy

4. Acute sickle cell disease

5. Unstable disease (does not apply to diabetic recipients whose condition is controlled by oral medications, diet, or insulin)

6. Hemophilia or other blood clotting disorders

If the provider believes that the recipient meets the requirements for an exemption from the 24 ambulatory medical visit limits and has received a denial for visits billed, the provider may request an exemption. To request an exemption, the provider must submit the request in letter form, stating the recipient's name and Medicaid identification number, and the recipient's primary diagnosis. Medical documentation supporting the exemption must also be included with the request. A prescription written by the physician is unacceptable documentation and will not be accepted. The letter and denied claim must be sent to:

EDS – Medical Director

P.O. Box 300001

Raleigh, NC 27622

The medical director reviews each request and responds in writing with either an approval or denial of the request for the exemption from the 24 ambulatory medical visit limit.

How to Request an Appeal

If the request for exemption is denied, the recipient will be notified in writing. The notice will explain how the decision may be appealed. For further information about recipient appeal rights, please refer to the section on appeal rights found in this manual.

Co-payments

The following co-payments apply to all Medicaid recipients except those specifically exempted by law from co-payment.

Service	Co-payment
Chiropractic	$2.00 per visit
Dental	$3.00 per visit
Prescription Drugs and Insulin – Generic/ Brand Name	$3.00 per prescription
Ophthalmologist	$3.00 per visit
Optical supplies and services	$2.00 per visit
Optometrist	$3.00 per visit
Outpatient	$3.00 per visit
Physician	$3.00 per visit
Podiatrist	$3.00 per visit

Providers may bill the patient for the applicable co-payment amount, but may not refuse services for inability to pay co-payment. **DO NOT ENTER CO-PAYMENT AS A PRIOR PAYMENT ON THE CLAIM FORM**. The co-payment is deducted automatically when the claim is processed.

Co-payment Exemptions

Providers may not charge co-payments for the following services:
- Ambulance services
- Dental services provided in a health department
- Diagnostic x-ray
- Durable medical equipment (DME)
- Family planning services
- Federally Qualified Health Center (FQHC) core services
- Health Check-related services
- Hearing aid services
- HIV case management
- Home health services
- Home infusion therapy (HIT)

- Hospice services
- Hospital emergency department services including physician services delivered in the emergency department
- Hospital inpatient services (inpatient physician services **are not** exempt)
- Laboratory services performed in the hospital
- Mental health clinic services
- Non-hospital dialysis facility services
- Private duty nursing (PDN) services
- Rural Health Clinic (RHC) core services
- Services **covered by both** Medicare and Medicaid
- Services in state-owned psychiatric hospitals
- Services provided to participants in the Community Alternatives Programs (CAP)
- Services provided to residents of nursing facilities, intermediate care facilities for mental retardation (ICF-MR), and psychiatric hospitals
- Services related to pregnancy
- Services to individuals under the age of 21

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid law, 1905(r) of the Social Security Act (the Act), that requires the state Medicaid agency to provide to Medicaid recipients under 21 years of age "necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." (A screening examination includes any evaluation by a physician or other licensed clinician). This law means that for recipients under 21 years of age, Medicaid must cover some services not available to the rest of the state's Medicaid population. That is, there is no requirement that the requested service, product, or procedure be included in the North Carolina State Medicaid Plan. However, the service, product, or procedure must be included in the list of coverable services found in 1905(a) of the Act, and the service, product, or procedure must be medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a licensed clinician. Additionally, EPSDT means that for recipients under 21 years of age, Medicaid will override coverage limits and criteria that apply to the rest of the state's Medicaid population if the criteria***** specified in this section are met. A listing of the EPSDT services is included in section 6 of this <u>Manual</u> on page 6-19.

Limits and Restrictions in Medicaid Coverage Criteria May Not Apply to Recipients Under 21 Years of Age

As a result of the federal law referred to as "EPSDT", service limitations on scope, amount, duration, and/or frequency and other specific criteria described in clinical coverage policies may be exceeded or may not apply to recipients under 21 years of age provided documentation shows that the requested service is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a licensed clinician.

Medical Services, Medical Products and Medical Procedures May be Available to Recipients Under 21 Years of Age that Are Not Covered for Recipients 21 Years of Age and Older

As a result of the federal law referred to as "EPSDT", Medicaid will cover some services that are **NEVER** covered for recipients 21 years of age and older. The Medicaid services available to recipients 21 years of age and over are limited to those set forth in the State Plan or in a Medicaid waiver. But, as stated above, recipients under 21 years of age may receive services, products and procedures which although not included in the State Plan are coverable under federal Medicaid law. "Coverable under federal Medicaid law" means that the service, product or procedure is described in Section 1905(a) of the Social Security Act and is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. Medicaid must prior approve such services. To initiate a prior approval request for these EPSDT services, please refer to section 6 of this Manual which fully describes the **prior approval process** for EPSDT and how to submit EPSDT requests. EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is unsafe, ineffective, or experimental/investigational.

*EPSDT criteria are specified below, and all of the criteria below must be met to approve coverage under EPSDT.

1. The service, product, or procedure must be included in the list of coverable services found in 1905(a) of the Social Security Act. See section 6 of this Manual, page 6-19.

2. The service, product, or procedure is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination.

3. The service, product, or procedure must be safe and effective.

The service, product, or procedure cannot be experimental/investigational